Virginia Medicaid Reform: Overview for the Medicaid Revitalization Committee

Department of Medical Assistance Services

July 14, 2006

Presentation Outline

- ***Legislative Mandate of the Medicaid Revitalization Committee***
- Overview of the Virginia Medicaid Program
- Florida Reform Model
- Comparison of HB758, Florida Reform, and Current Virginia Medicaid
- Future Meeting Dates / Proposed Agendas

The Origin of the Medicaid Revitalization Committee

- House Bill 758 (HB758), passed by the 2006 General Assembly and signed by Governor Kaine on April 5, 2006, sets into motion a self-examination of Virginia's primary healthcare delivery mechanism for the State's most vulnerable citizens – the Medicaid program.

- The legislation directs the Department of Medical Assistance Services (DMAS) to create a group consisting of patient advocates, healthcare providers, health insurers, program administrators, and other stakeholders – the Medicaid Revitalization Committee – to examine alternative and innovative approaches to healthcare delivery under Medicaid, with a focus on client-centered planning, individual budgeting, and self-directed quality assurance and improvement.

The Mission of the Medicaid Revitalization Committee

- The Committee's mission is to consider potential revisions to the program as identified in HB758, and based on its deliberations, to make recommendations regarding the future structure of Virginia's Medicaid program. The Committee's recommendations will focus on:

  - emphasizing the state's role in purchasing healthcare services,
  - leveraging market forces to customize services to meet the diverse needs of Virginia's Medicaid population,
  - enhancing personal responsibility and empowering individuals who desire to manage their healthcare,
  - bridging public and private coverage,
  - maximizing access, and
  - containing the growth of Medicaid expenditures in the Commonwealth

Overview of the Medicaid Revitalization Committee's Mandate

- The Medicaid Revitalization Committee is directed to consider several potential reforms to the Medicaid program, including:
  - the creation of an incentive structure to promote increased personal responsibility in the healthcare decisions of Medicaid recipients
  - increased enrollment from "un-managed" delivery models to care-coordination programs – Medicaid managed care, primary care case management, and disease management
  - the creation of voluntary enhanced benefit accounts, or health opportunity accounts, to facilitate healthy behavior and training in effective and appropriate self-care
    - to facilitate a recipient's ability to purchase qualifying services or items outside the scope of basic coverage thereby further promoting the well-being of the Medicaid recipient and potentially diminishing future utilization of acute care services

Overview of the Medicaid Revitalization Committee's Mandate
(continued)

  - the creation of additional mechanisms for purchase of employer-sponsored health insurance through health benefits accounts funded at the actuarially defined risk-based premium cost that would otherwise be borne by the Medicaid program as a direct insurer
  - phased implementation of direct electronic access to the enhanced benefit accounts for recipients and fully implemented electronic funds transfer technology for providers and participating managed care organizations

- By December 1, 2006, DMAS shall submit a report of the Committee's findings and recommendations to the Governor, the House Committees on Appropriations and Health, Welfare and Institutions, and the Senate Committees on Finance and Education and Health.

Additional Medicaid Reform Role of the Revitalization Committee

- In addition to the mandate enumerated by HB758, DMAS intends to use the Committee's varied expertise to provide input on optional Medicaid reform opportunities found in the federal Deficit Reduction Act of 2005 (DRA).
  - The DRA was signed into law on February 8, 2006 by President Bush.
  - For state Medicaid programs, the DRA represents a mix of mandated and optional reforms.
  - The expressed intent behind the DRA, in relation to Medicaid, was an opportunity for states to modernize their Medicaid delivery systems through more flexibility and recognition of alternate approaches to the desired program outcomes.

Additional Medicaid Reform Role of the Revitalization Committee

(continued)

- While many of the DRA provisions are mandatory for state Medicaid programs, a number of optional provisions were included. DMAS would like to solicit input from the Committee on three general optional DRA reform topics:
  - Increased flexibility in premiums and other cost sharing design
  - Increased flexibility in benefit design, including variability in benefits and the use of benchmark packages
  - The Family Opportunity Act
- While these topics will not be part of the Committee's report, DMAS would like to solicit input on these DRA provisions from the various stakeholders

Limitations on the Role of the Revitalization Committee

- The Medicaid Revitalization Committee is not intended to be a forum for discussion of Long-Term Care / Acute Care Integration – DMAS will solicit input separately on the agency's initiatives regarding various integration models for the management of Long-Term and Acute Care services for the elderly and disabled

- The Medicaid Revitalization Committee is not intended to be a forum for discussion of payment adequacy concerns in the provider community, nor is it intended to be a forum for the discussion of payment structure modifications beyond those related to provisions of HB758

Limitations on the Role of the Revitalization Committee

(continued)

- The Medicaid Revitalization Committee is not intended to be a forum for discussion of mandatory DRA provisions and their implementation in Virginia. DMAS intends to fully inform stakeholders regarding implementation issues arising from federally mandated reform provisions and would be happy to hear any DRA concerns outside of this Committee's forum. Mandatory DRA reforms include:

  - Long-Term Care Eligibility Asset Sheltering provisions
  - Citizenship/Identity Documentation provisions
  - Prescription Drug Reimbursement-related (non-cost sharing) provisions
  - Target Case Management provisions
  - Third Party Liability provisions
  - Medicaid Integrity Program provisions

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Medicaid Is The Largest Healthcare Program In Virginia (and the US)

- In FY 2004, Virginia Medicaid provided reimbursement for an average of 625,000 recipients per month at a total cost of $3.8 billion
- By FY 2005, Medicaid was serving nearly 691,000 recipients per month with annual expenditures of $4.4 billion
- Program costs are shared by the state and federal government
  - federal share is higher in states with lower per capita income
- Virginia's federal match rate is 50 percent
- For the children's health program -- FAMIS -- Virginia's federal match rate is 67 percent

Program Eligibility Is Organized Around Several Mandatory Groups

- To receive Medicaid recipients must be categorically eligible and meet the program's financial test
- Eligibility Categories:
  - Aged, blind or disabled
  - Member of a family with children
  - Pregnant woman
  - Certain Medicare beneficiaries
- Coverage for persons in these groups is mandatory as long as they meet the financial (income and resource limits) criteria for the program

Virginia Also Covers Groups That Are Optional Under Federal Law

- Optional groups include but are not limited to:
  - Medically needy persons whose income exceeds established limits but who are impoverished by medical bills
  - Persons in institutions or Medicaid Home and Community Based waivers (e.g., nursing homes, intermediate care facilities for the mentally retarded)
  - Certain aged, blind, or disabled adults who are not on SSI

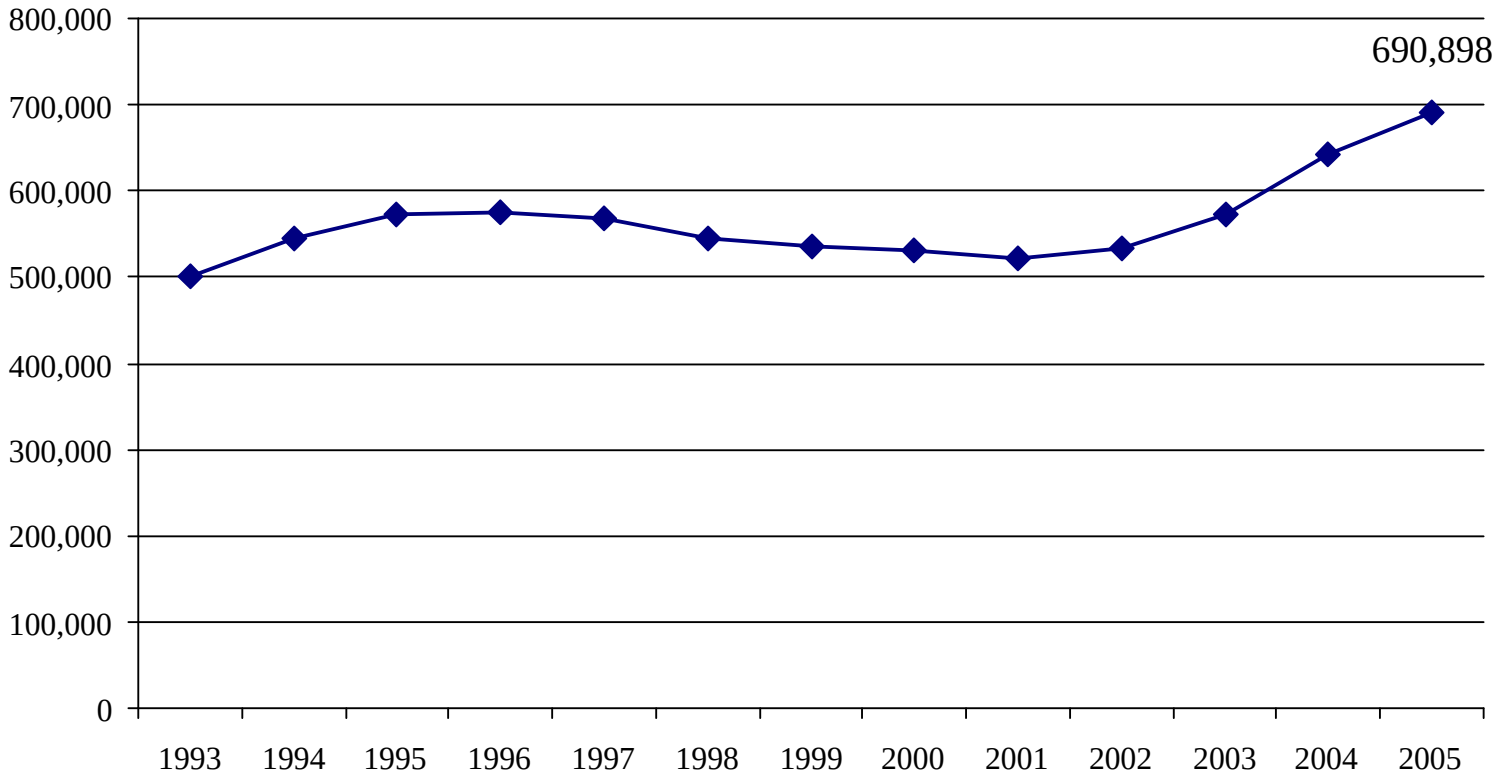
Mandatory Medicaid Services

- Hospital Inpatient, Outpatient, & Emergency Services
- Nursing Facility Services
- Physician Services
- Medicare Premiums, copays and deductibles (Part A and Part B)
- Certified Pediatric Nurse & Family Nurse Practitioner Services
- Certain Home Health Services (nurse, aide, supplies and treatment services)
- Laboratory & X-ray Services
- Early & Periodic Screening, Diagnostic & Treatment (EPSDT) Services
- Nurse-Midwife Services
- Rural Health Clinics
- Federally Qualified Health Center Clinic Services
- Family Planning Services & Supplies
- Transportation

Optional Medicaid Services Provided in Virginia

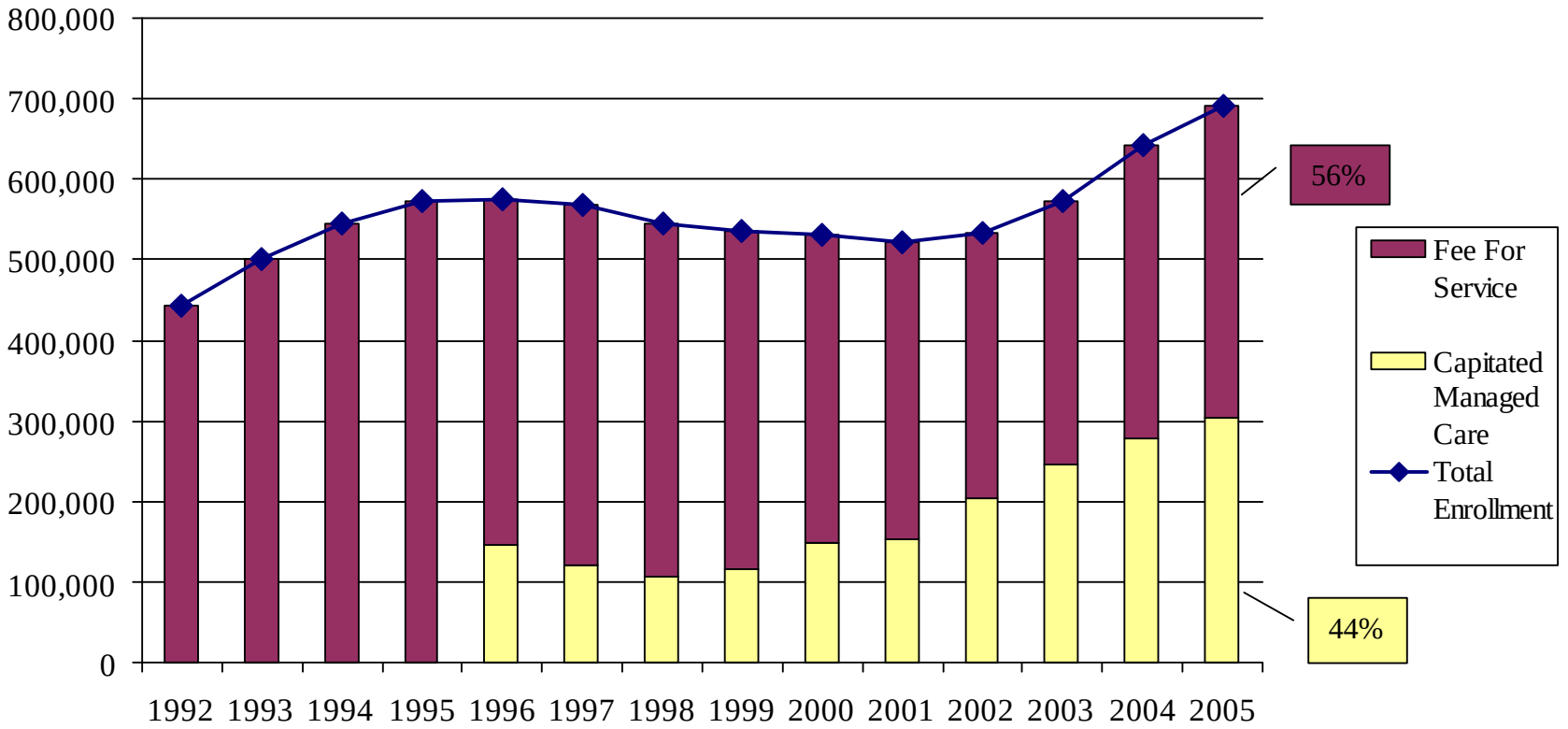
- Prescribed Drugs
- Mental Health & Mental Retardation Services
- Home & Community-Based Care Waiver Services
- Skilled Nursing Facility Care for Persons under age 21
- Dental Services for Persons under age 21
- Physical Therapy & Related Services
- Clinical Psychologist Services
- Podiatrist Services
- Optometrist Services
- Services provided by Certified Pediatric Nurse & Family Nurse Practitioner
- Home Health Services (PT, OT, and Speech Therapy)
- Case Management Services
- Prosthetic Devices
- Other Clinic Services
- Hospice Services
- Medicare Premiums/copays/ deductibles

Medicaid Enrollment Trends



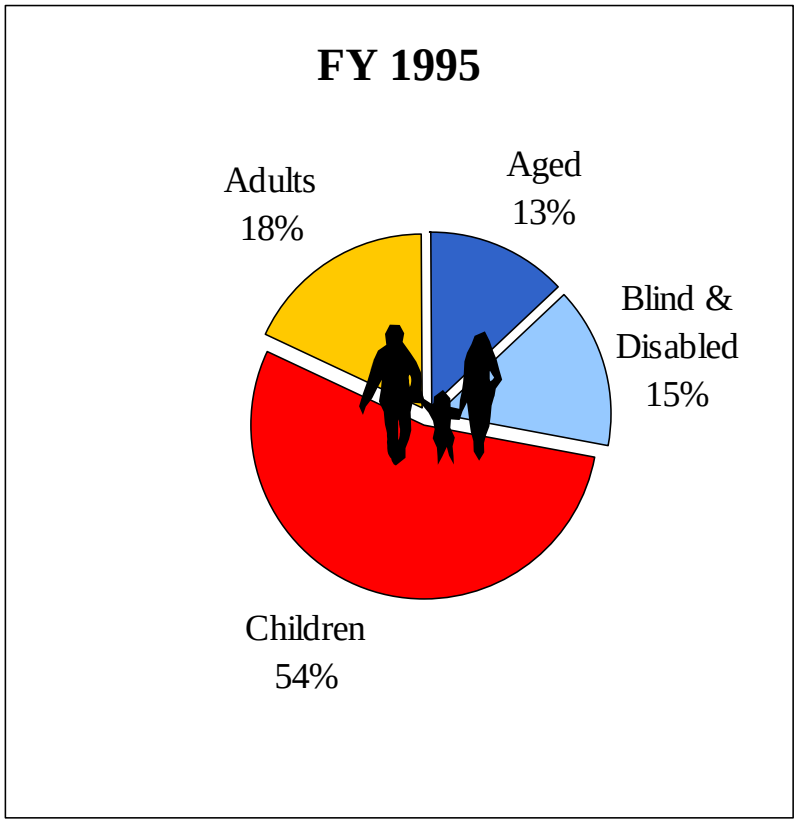
Notes: Average monthly enrollment in the Virginia Medicaid Program

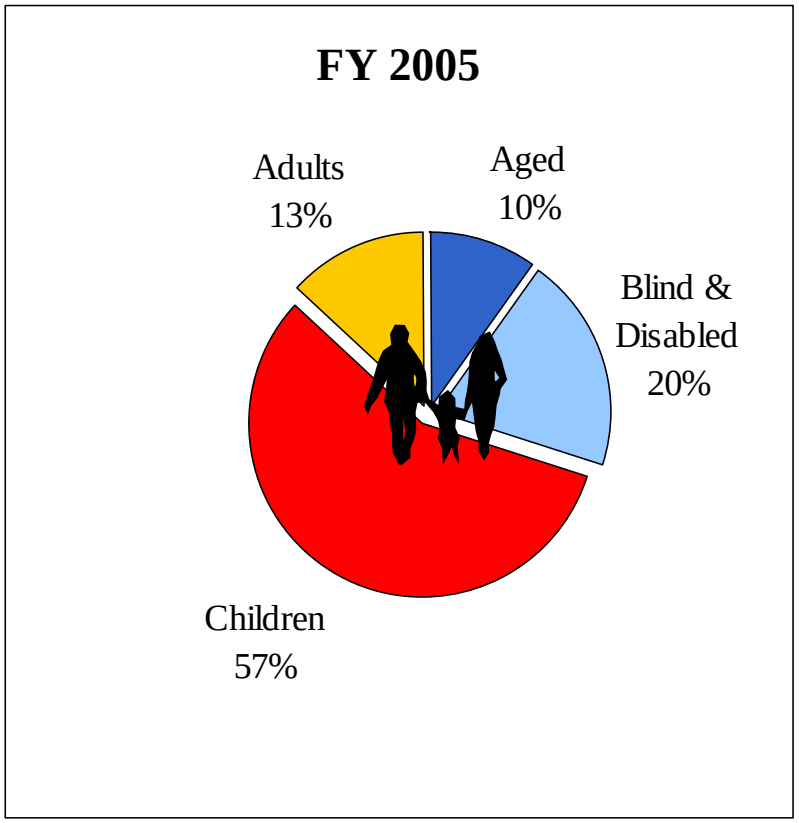
Medicaid Enrollment Trends
(by Service Delivery Type)



Notes: Average monthly enrollment in the Virginia **Medicaid** Program (this does not include the Medicaid Expansion and FAMIS programs – inclusion of these programs also administered by DMAS would push the capitated services well above 50 percent of the distribution by service delivery type).
Capitated Care consists of the Options and Medallion II programs.

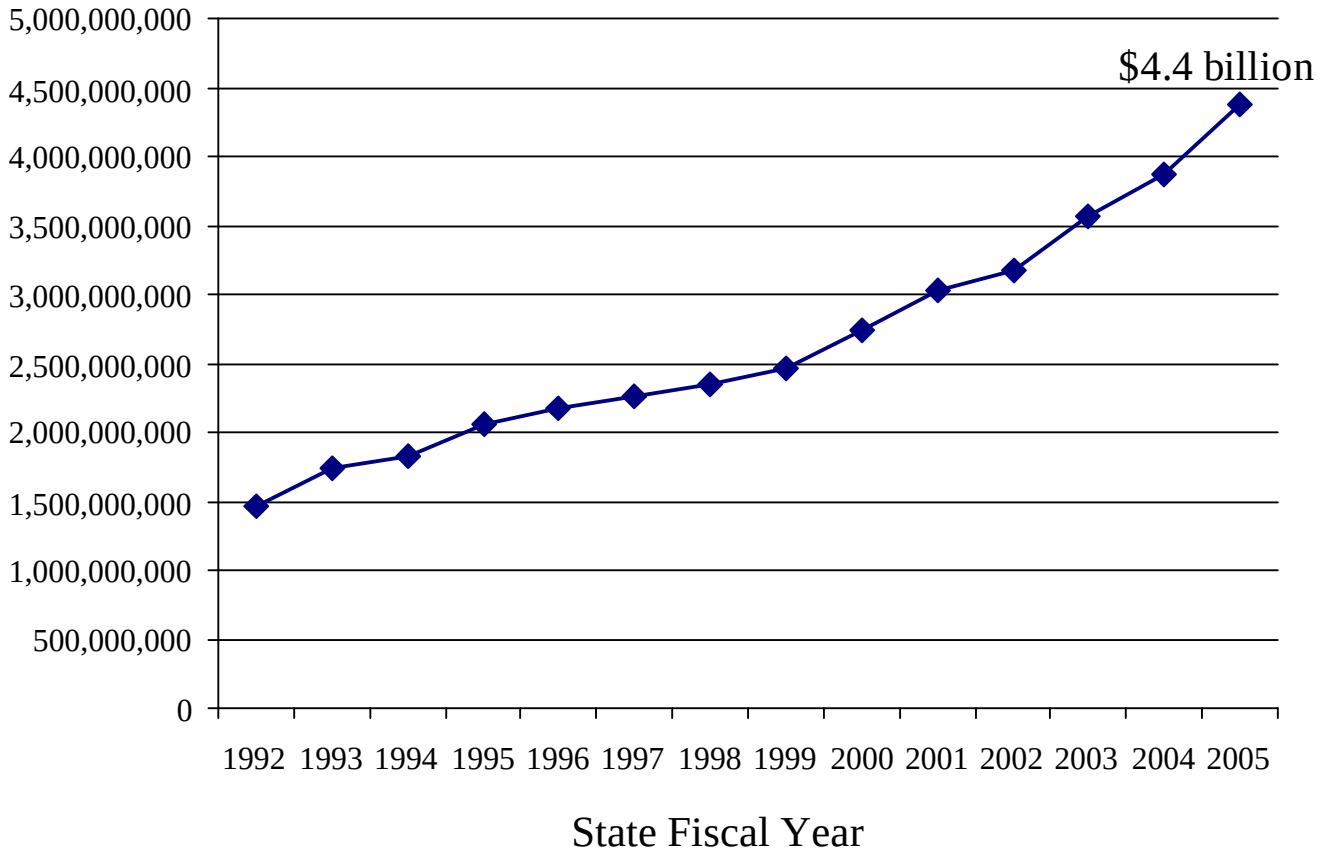
Medicaid Enrollment Trends
(by Eligibility Category)



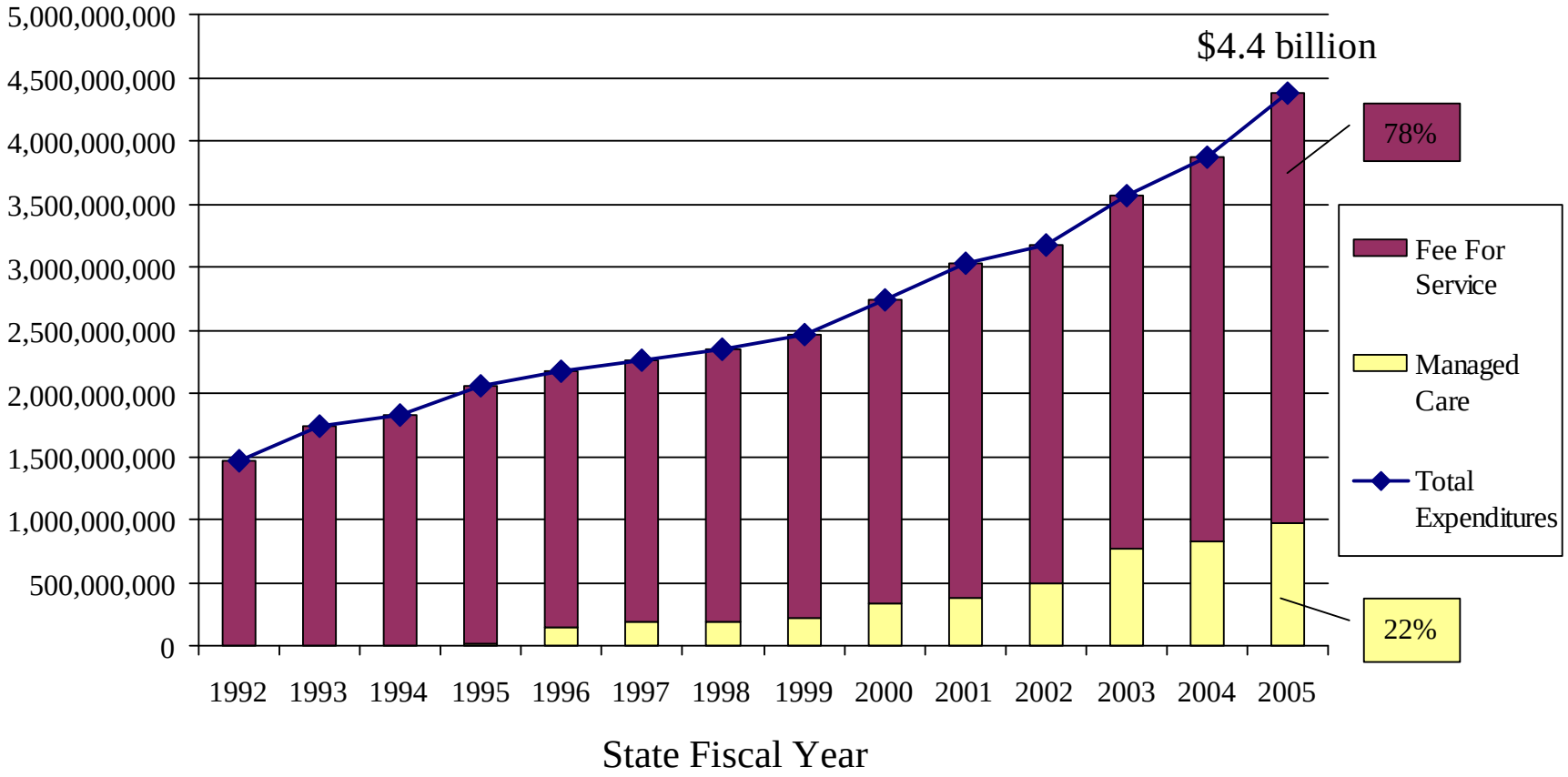


Notes: Annual unduplicated enrollment in the Virginia Medicaid program

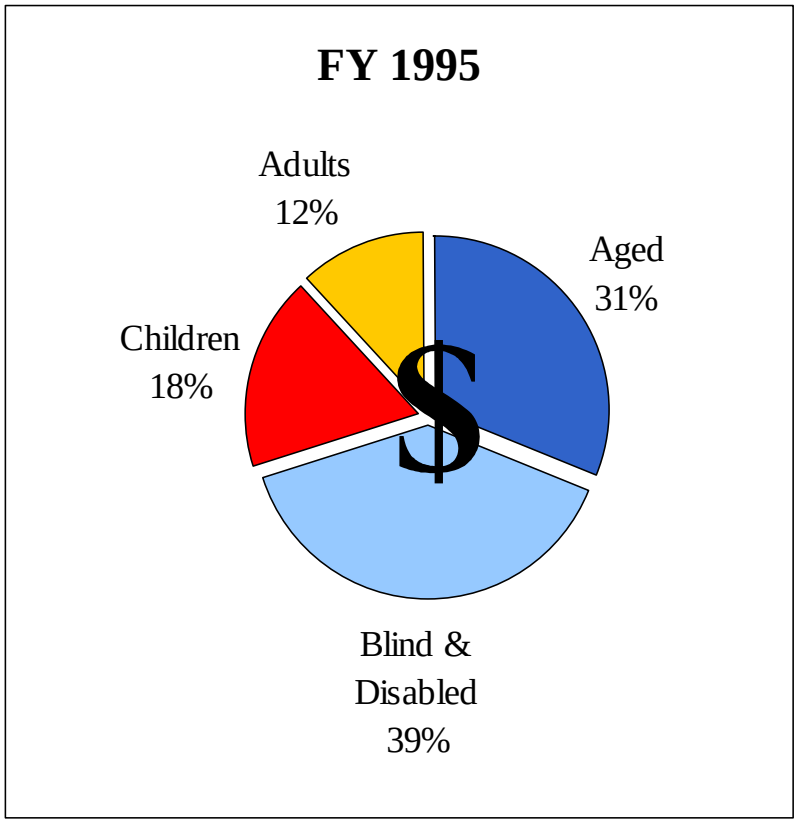
Medical Services Expenditure Trends

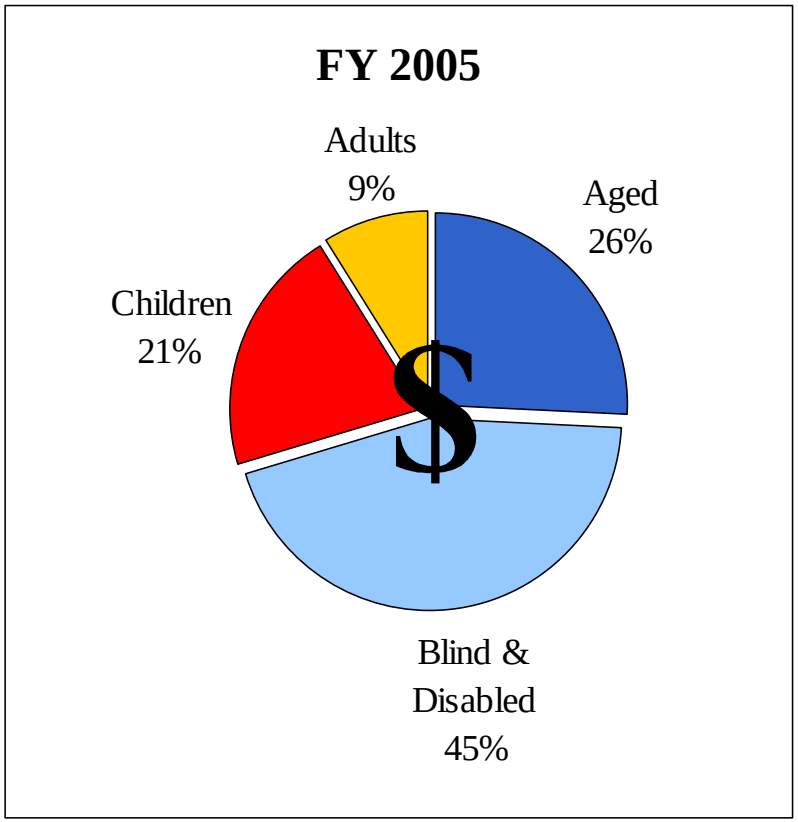


Medical Services Expenditure Trends
(by Service Delivery Type)

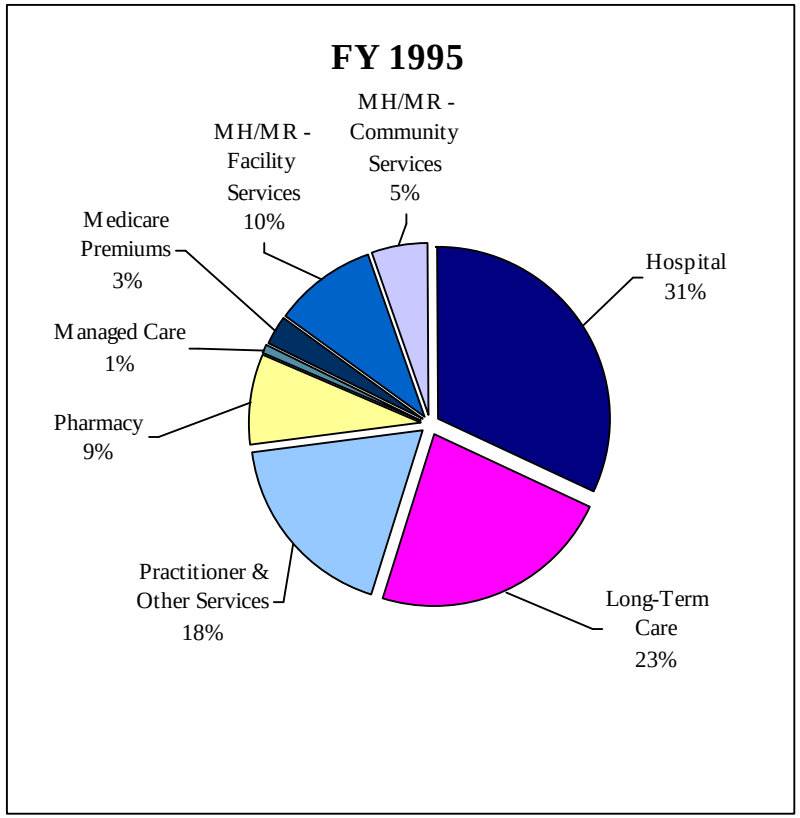


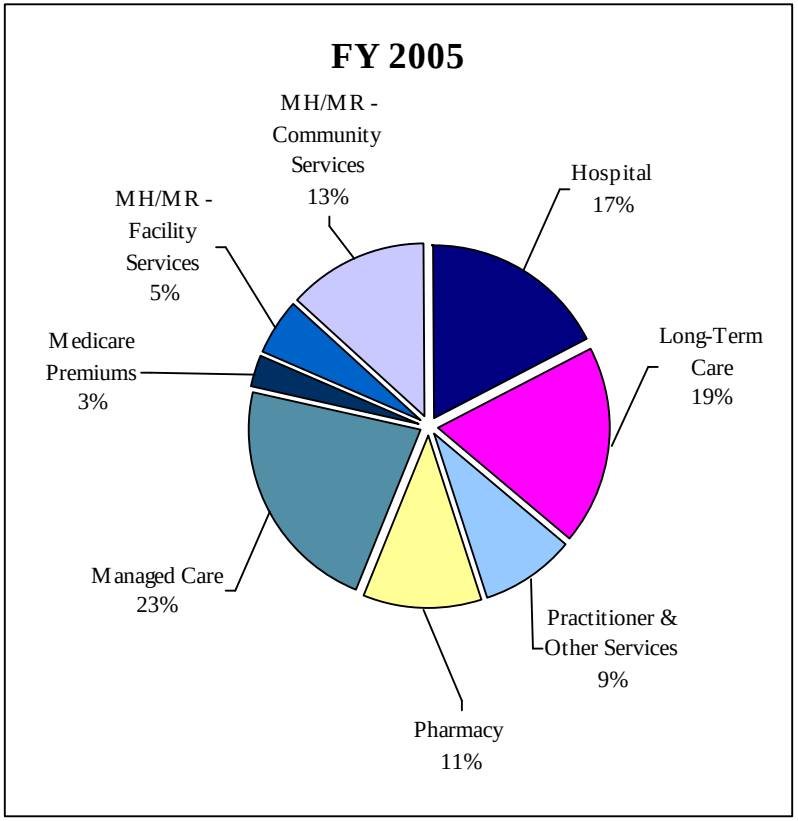
Medical Services Expenditure Trends
(by Eligibility Category)



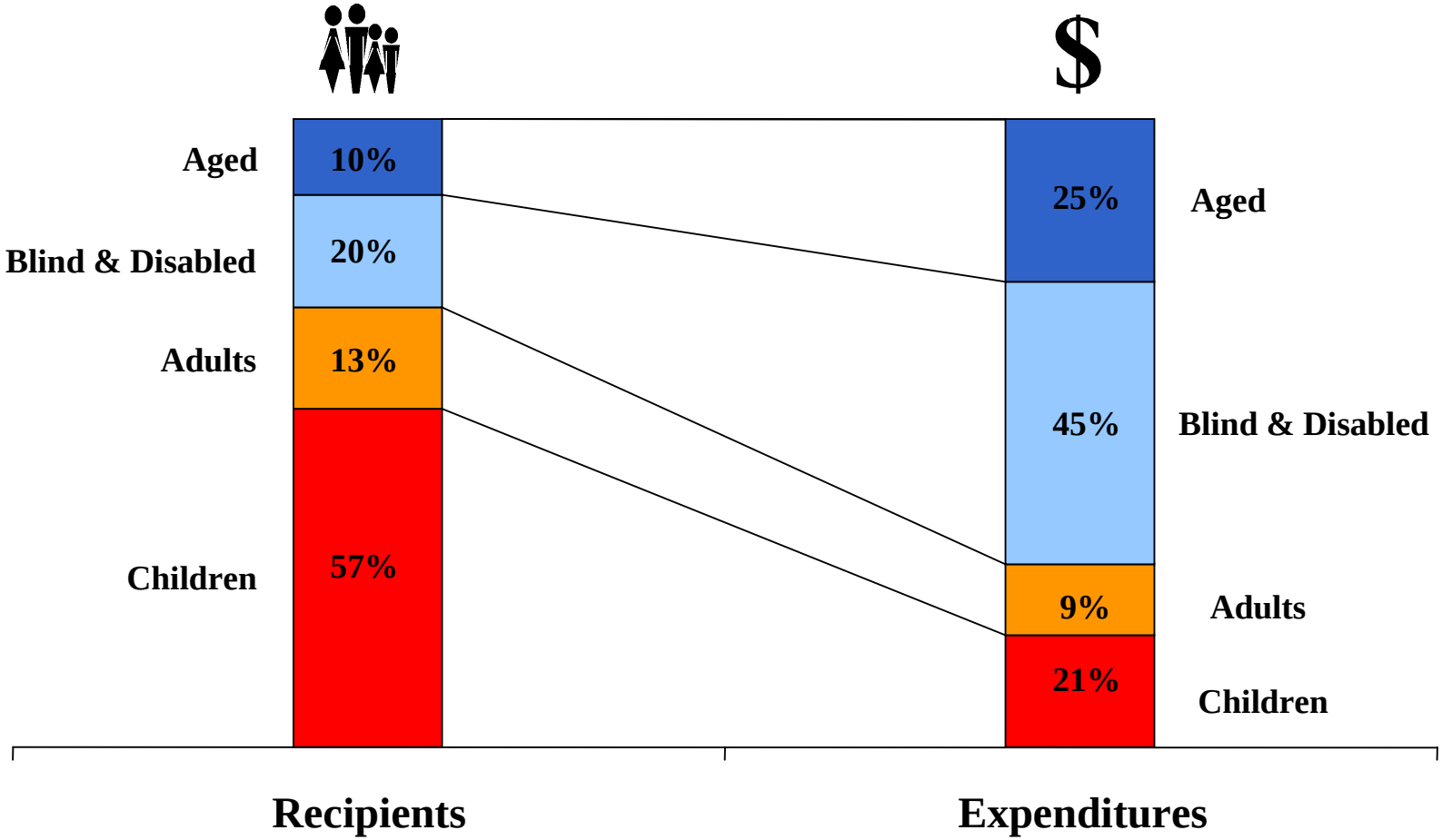


Medical Services Expenditure Trends
(by Service Category)



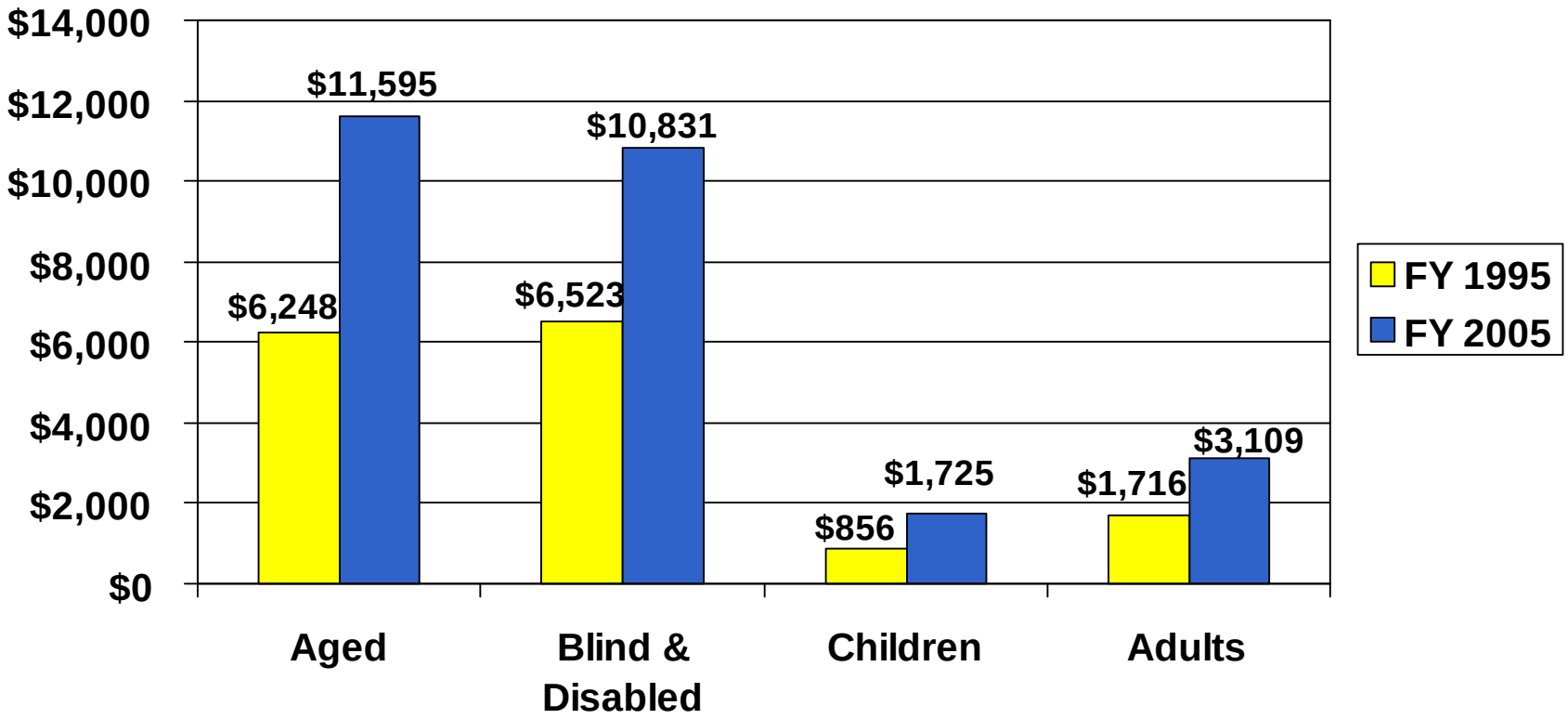


Medicaid Enrollment & Expenditures
(FY 2005)



Medicaid Expenditure Trends

Average Annual Cost per Enrollee



Virginia Compared to Other States

Measure	Rank
Total Population[1]	12th
Per Capita Income[1]	7th
Number of Medicaid Recipients[2]	24th
Number of Medicaid Recipients as % of Population[2]	47th
Expenditure Per Medicaid Recipient[2]	27th
Medicaid Expenditure Per Capita[2]	49th

Sources: [1] U.S. Bureau of Economic Analysis Regional Economic Information System, 2004 data released 9/28/2005
[2] Urban Institute and Kaiser Commission estimates based on data from CMS-64 reports, September 2005.

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Florida's Medicaid Reform:
Background

- The reform was authorized by Florida Legislature on May 6, 2005
- Florida submitted a waiver request to the Centers for Medicare and Medicaid Services (CMS) on October 3, 2005
- The waiver request approved by CMS on October 19, 2005
- The Florida Legislature approved the final reform plan on December 8, 2005
- The initial phase-in of the Medicaid reform began on July 1, 2006 in Duval and Broward Counties

Florida's Medicaid Reform:
Intent

- Much like the expressed intent of HB 758, Florida's Medicaid reform effort is designed to:
  - Increase recipient choice
  - Empower recipients to participate in health care
  - Encourage benefits that better meet recipient needs
  - Allow access to services not traditionally covered by Medicaid
  - Reward recipient healthy behavior and choices
  - Bridge the gap to private insurance
- According to Florida officials, it is ***not*** designed to:
  - Change who receives Medicaid
  - Cut the Medicaid budget
  - Limit EPSDT or medically necessary services
  - Increase recipient cost sharing

Key Elements of Florida's Medicaid Reform : Summary

- New Options / Choice:
  - Customized benefit plans
  - Ability to "opt-out" of Medicaid and participate in employer-sponsored or private insurance with public subsidy
  - Enhanced benefit rewards for healthy behaviors

- Financing:
  - Risk-adjusted premium-based
  - Comprehensive and catastrophic components

- Delivery System:
  - Coordinated systems of care (Provider Service Networks and Health Maintenance Organizations)

Key Elements of Florida's Medicaid Reform : Customized Benefits

- Under the Florida reform initiative:
  - Reform plans can enhance any service above current levels
  - Reform plans can add services not currently covered - for example:
    - over-the-counter medications
    - adult preventative dental services
    - nutrition counseling

- While plan design flexibility now exists, there are certain parameters:
  - Certain services must be provided at or above current coverage levels
  - Other services must be provided to meet sufficiency standards for the population
  - Remaining services must be offered, but amount, scope and duration are flexible

Key Elements of Florida's Medicaid Reform : Customized Benefits

(continued)

- To be approved, reform plans must demonstrate that they are :
  1. Actuarially equivalent to pre-reform Medicaid
     a) How does the value of proposed benefits compare to historical Medicaid for the target population?
     b) Is the overall financial value of benefits appropriate?

  2. Sufficient to meet medical needs:
     a) Are medical services provided at sufficient levels to serve the target population?

- Actuarial equivalence and sufficiency are data driven

Key Elements of Florida's Medicaid Reform : Medicaid Opt-Out

- Recipient can choose to enroll in employer-sponsored health insurance instead of a Medicaid-certified plan
- Self-employed individuals may purchase private insurance
- Medicaid will pay the employee share of the employer-sponsored premium on behalf of the recipient
- Individuals with access to employer-sponsored insurance may opt-out at any time

Key Elements of Florida's Medicaid Reform : Enhanced Benefits

- A pool of funds is set aside to encourage recipients to engage in "Healthy Behaviors"
- Individual Medicaid recipients earn access to "credit" dollars from the pool by completing defined healthy practices and/or behaviors
- Once credits are earned, they may use a debit card to purchase health-related services and products
- Earned credits may be used during or within three years following cessation of Medicaid eligibility

Key Elements of Florida's Medicaid Reform : Enhanced Benefits

(continued)

- Examples of healthy behaviors:
  - Attendance of childhood semi-annual dental exam
  - Active participation in disease management program (if relevant)
  - Attendance of recommended childhood vision exams
  - Receipt of flu shot (if physician recommended)
  - Attendance of regularly scheduled mammograms
  - Receipt of scheduled childhood immunizations
  - Active participation in alcohol/drug treatment program (if relevant)
- Examples of health related supplies for purchase through enhanced benefit accounts:
  - Over-the-counter medications
  - Vitamins
  - First Aid products
  - Orthopedic aids

Key Elements of Florida's Medicaid Reform : Premium Based Financing

- Statistical models correlate historical diagnoses / pharmaceutical utilization to the likelihood of future health care cost.
- Individuals are assigned a "risk score."
- Individual risk scores generate premium, based on recipient's predicted needs.
- Health plans are credited with risk score / premium of each individual enrolled.
- Collective risk scores / premiums of members generate health plan revenues / capitation tied to expected health costs.

Key Elements of Florida's Medicaid Reform : State Reinsurance

- Florida provides an option to reform plans to provide comprehensive and catastrophic benefits, or comprehensive benefits only, with the state covering catastrophic needs through a fee-for-service system (once a certain cost threshold is exceeded)
  - comprehensive risk is always borne by the health plan; catastrophic risk may be borne by the plan or the state (Florida officials have indicated that all existing MCOs must assume the catastrophic risk; the option only exists for a limited period for new Provider Service Networks and MCOs
  - continuous coverage of benefits: the transition between comprehensive and catastrophic components is transparent to the recipient
  - All care continues to be managed by the health plans.

Key Elements of Florida's Medicaid Reform : Delivery Models

- Provider Service Networks (PSNs): May be separate providers organized as one network or (more likely) highly integrated health systems
  - The Florida reform plan allows PSNs to be paid on a capitated or fee-for-service (FFS) basis. If FFS, this is only allowed for the first two years, then the PSN must transition to capitated payment
    - according to Florida officials, PSNs paid at their option on a FFS basis in the first two years will be subject to payment reconciliation to the equivalent capitated payment amount
- Health Maintenance Organizations (HMOs)
- Other licensed insurers

Florida's Medicaid Reform:
Status Update

- As of June 23, 2006, 18 reform plan applications had been received
  - 7 Provider Service Networks (PSNs)
  - 11 Health Maintenance Organizations (HMOs)
- Effective July 1, 2006, 10 HMOs and 3 PSNs will be under contract with Florida Medicaid
- Risk adjusted rates have been developed
- Choice Counselors have been hired/trained to assist recipients in making plan choices

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Comparison of HB758, Florida Reform and the Current Virginia Medicaid Program

House Bill 758 Provision	Florida Medicaid Reform	Virginia Medicaid Currently
Creation of an incentive structure to promote increased personal responsibility in healthcare decisions	Has a pool of funds set aside for recipients to access based on exhibition of healthy behaviors. These funds can be used to purchase non-covered, but health-related products or services	Both fee-for-service and managed care recipients with certain chronic conditions have access to disease management programs which often utilize a reward structure for adherence to the recommended plan of care. In the fee-for-service program, this is limited to diabetes (adult and child), asthma (adult and child), coronary artery disease (adult) and congestive heart failure (adult). Individuals who do not have these chronic conditions in the fee-for-service program do not have access to this care management and any reward structure utilized.

Comparison of HB758, Florida Reform and the Current Virginia Medicaid Program

(continued)

House Bill 758 Provision	Florida Medicaid Reform	Virginia Medicaid Currently
Increased enrollment from "un-managed" delivery models to care-coordination programs – Medicaid managed care, primary care case management, and disease management	The Florida reform effort will eventually expand Medicaid managed care throughout the state, but certain populations, such as institutionalized individuals are not included in the reform changes	In fiscal year 2005, 56 percent of Medicaid/Medicaid Expansion/FAMIS enrollees were served through a managed care organization (approximately 75 percent of all Medicaid children). Since 2001, more than 243,000 recipients have been added to managed care. Additional expansions are occurring in September 2006 and more are in planning stages for the future. Certain populations, primarily the elderly and disabled who are institutionalized or are receiving waiver services, and those with third-party insurance (including the Medicare dual eligibles) are categorically excluded from Medicaid managed care. Geographic regions, primarily the far Southwest portion of Virginia, have little or no commercial managed care penetration. However, most Medicaid recipients who are managed care eligible participate in the Primary Care Case Management program, MEDALLION.

Comparison of HB758, Florida Reform and the Current Virginia Medicaid Program

(continued)

House Bill 758 Provision	**Florida Medicaid Reform**	**Virginia Medicaid Currently**
The creation of voluntary enhanced benefit accounts, or health opportunity accounts, to facilitate healthy behavior and training in effective and appropriate self-care	For clients that participate in activities that promote health behavior, the state deposits funds into an enhanced benefit account which can be used to purchase health-related goods and services not otherwise covered by Medicaid	Virginia does not have anything comparable to an enhanced benefit account for either fee-for-service or managed care recipients

Comparison of HB758, Florida Reform and the Current Virginia Medicaid Program

(continued)

House Bill 758 Provision	Florida Medicaid Reform	Virginia Medicaid Currently
The creation of additional mechanisms for purchase of employer-sponsored health insurance through health benefits accounts funded at the actuarially defined risk-based premium cost that would otherwise be borne by the Medicaid program as a direct insurer	The entire payment structure for the Florida reform utilizes risk-based premiums. If the recipient participates in a reform plan, the plan is reimbursed based on the risk-based premium calculated for each individual recipient. The recipient can choose to opt-out of Medicaid and purchase employer-sponsored or private insurance, with the state contributing to that cost up to the risk-based premium amount. Florida is initially using pharmacy data to determine the risk of individuals for premium determination; they will eventually migrate to the Chronic Illness and Disability Payment System (CDPS) once encounter data are available.	Virginia currently offers public assistance to Medicaid eligibles with the purchase of employer sponsored health insurance through the Health Insurance Premium Payment (HIPP) program for Medicaid and the FAMIS Select program for FAMIS. Additionally, the Medicaid managed care program (Medallion II) has utilized risk-based premiums based on the CDPS system for several years. The Virginia approach aggregates risk scores and premiums into sixteen age/sex/aid category groups across five health plans and five regions, whereas the Florida approach appears to remain individualized.

Comparison of HB758, Florida Reform and the Current Virginia Medicaid Program

(continued)

House Bill 758 Provision	Florida Medicaid Reform	Virginia Medicaid Currently
Phased implementation of direct electronic access to the enhanced benefit accounts for recipients and fully implemented electronic funds transfer technology for providers and participating managed care organizations	The Florida reform effort encourages the use of electronic billing and electronic funds transfer as the preferable payment transaction. The Florida program will allow for debit card transactions from enhanced benefit accounts in the purchase of health related goods and services	Virginia Medicaid uses electronic funds transfer as the preferred payment transaction and encourages providers to enroll, but this is not required at this time. In addition, DMAS is working toward web-based claims submission for Medicaid providers Since Virginia does not currently have enhanced benefit accounts, direct access to accounts also does not currently exists.

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Medicaid Revitalization Committee Web Page

- Go to http://www.dmas.virginia.gov/ and click on Medicaid Revitalization Committee link under “What’s New”

- Web site will contain:
  - House Bill 758
  - Medicaid Reform in Virginia concept paper
  - Committee member/organization names
  - meeting materials (as developed)
  - official meeting minutes (as developed)
  - future meeting dates/times/locations
  - report draft (as developed)

- E-mail comments/concerns to MRC@dmas.virginia.gov

August 2, 2006
(9:00am – 12:00pm, DMAS)

Proposed Agenda

- Public Comment on Medicaid Reform in Virginia
  - Comments will be limited to five minutes per speaker/organization
- Disease Management Programs
- Enhanced Benefit Accounts
- Enhanced Electronic Access
  - to enhanced benefit accounts (debit cards)
  - to electronic funds transfer (providers and managed care plans)

August 9, 2006
(9:00am – 12:00pm, DMAS)

Proposed Agenda

- Managed Care in Medicaid

- Optional Provisions of the Deficit Reduction Act
  - Cost Sharing/Premium Structure
  - Benefit Design Flexibility

August 29, 2006
(9:00am – 12:00pm, DMAS)

Proposed Agenda

- Employer-Sponsored Health Insurance Options / Public Insurance Buy-In
  - Family Opportunity Act (optional provision of the DRA)

- Summary of Committee Deliberations to Date

September 21, 2006
(9:00am – 12:00pm, DMAS)

Proposed Agenda

- Presentation of Draft Committee Report
- Public Comment
  - Comments will be limited to five minutes per speaker/organization

October 10, 2006
(9:00am – 12:00pm, DMAS)

Proposed Agenda

- Formal Adoption of Committee Report

November 8, 2006
(9:00am – 12:00pm, DMAS)

Proposed Agenda

(If Necessary)